Superior Court of California
County of Santa Clara
Human Resources
191 North First Street
San José, CA 95113
Telephone: (408) 882-2703
Fax: (408) 882-2796
Email: RetireeBenefits@scscourt.org

RETIREE MEDICAL PLAN ENROLLMENT AND CHANGE FORM

☐ Retiree ☐ Survivor of Retiree

SECTION 1: Retiree/Survivor of Retiree Information

Name: _____ Social Security Number: _____

Date of Birth: _____ Address: _____

Home Phone Number: _____ Email Address: _____

SECTION 2: Type of Change

☐ Change my Medical Plan
☐ Add Eligible Dependents
☐ Open Enrollment
☐ Terminate Medical Plan Coverage
☐ Enroll in a Medical Plan
☐ Remove Dependents from Medical Plan
☐ Qualifying Event (*birth, marriage, Medicare Eligibility or loss of medical coverage*)

SECTION 3: Medical Plan

Name of new Medical Plan*: _____
**All plans require submittal of provider enrollment form. Please contact Human Resources.*

Name of Doctor/Medical Group *(if known)*: _____

SECTION 4: Dependent Information

Dependent Name: _____ Social Security Number: _____ Date of Birth: _____
Relationship: _____ Gender: _____ Doctor or Medical Group: _____

Dependent Name: _____ Social Security Number: _____ Date of Birth: _____
Relationship: _____ Gender: _____ Doctor or Medical Group: _____

Dependent Name: _____ Social Security Number: _____ Date of Birth: _____
Relationship: _____ Gender: _____ Doctor or Medical Group: _____

SECTION 5: Additional Information

- If you have more than three dependents, please include their information on a separate page. Be sure to put you name and social security number at the top of the page.
- Monthly premiums vary depending on which plan you elect. See the current Retiree Medical Plan Rates or contact Human Resources if you do not see your plan listed.
- If you are enrolling eligible members on your retiree medical plan coverage, please attach marriage certificate, affidavit of taxation for Domestic Partnership with registration, or birth certificate.

SECTION 6: Retiree/Survivor of Retiree Signature

I certify that all of the information contained in this form is true and correct. I understand that I should confirm my effective date of coverage through Human Resources prior to seeking services from any provider. The Superior Court of California, County of Santa Clara is not responsible for services received prior to effective date of coverage.

Signature: _____ Date: _____

Human Resources Use ONLY – Do not write below this line.

Coverage start date: _____ Premium Payments begin date: _____ Initials: _____

Reset Form